DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155756		(X2) M ¹ A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE COMPI 09/02/2	LETED	
	PROVIDER OR SUPPLIER			7843 W	ADDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD VAYNE, IN46804	ļ	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Е	(X5) COMPLETION DATE
K0000	and State Licenconducted by the Department of accordance with Survey Date: Output Facility Number Provider Number AIM Number: 20 Surveyor: Amy Code Specialist At this Life Safe Coventry Mead in compliance of the National Fire Association (NF Code (LSC), Challed	th 42 CFR 483.70(a). 9/02/11 r: 004945 er: 155756 200814400 Kelley, Life Safety ety Code survey, ows was found not with Requirements in in caid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety apter 18, New cupancies and 410 facility was be of Type V (111)	K	0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1PQP21

Facility ID:

004945

TITLE

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	NSTRUCTION 01	(X3) DATE SURV COMPLETEI		
ANDILAN	OF CORRECTION	155756	A. BUILI			09/02/2011		
			B. WING		DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				JEFFERSON BLVD			
	RY MEADOWS				VAYNE, IN46804			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E CO	OMPLETION DATE	
1710		ne facility has a fire		ING	·		DATE	
	alarm system w	•						
	· ·	corridors, areas						
	open to the corridors and resident rooms. The facility has a capacity of 150 and had a census of 142 at							
the time of this survey.								
	Quality Review by Robert Booher, Life Safety							
Code Specialist-Medical Surveyor on 09/09/11.								
	The facility was found not in compliance with the							
	aforementioned	d regulatory						
	requirements a	s evidenced by the						
	following:							
K0038	Evit access is arra	nged so that exits are						
SS=F		at all times in accordance 18.2.1						
	Based on obser		K00	038	The creation and submission	of 10	0/02/2011	
	interview, the fa				this Plan of Correction does			
	ensure the mea				constitute an admission by the provider of any conclusion se			
		delayed-egress			forth in the statement of	^		
		lily accessible for			deficiencies, or of any violation	on of		
		aff and visitors.			regulation.			
	LSC 7.2.1.6.1, [This provider respectfully			
		all approved, listed,			requests that the 2567 Plan	of		
	delayed egress				Correction be considered the	I		
		installed on doors			Letter of Credible Allegation. This facility respectfully requests a			
	· •	d ordinary hazard			revisit on or after October 2,	1		
	_	ldings protected			2011.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1PQP21 Facility ID:

004945

If continuation sheet

Page 2 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155756		A. BUIL	DING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/02/2011	
	PROVIDER OR SUPPLIER		B. WING 09/02/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN46804			30.02.2011
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) K 038 NFPA 101 Life Safety Code Standard It is the practice of this facilit	DATE	
	approved, super sprinkler system accordance with where permitted through 42, properties adjacent to the there shall be a durable sign in than 1 inch high inch in stroke where the stroke where t	ervised automatic m installed in h Section 9.7, and d in Chapters 12 ovided: On the door release device, readily visible, letters not less h and at least 1/8 width on a			ensure that the Exit access is readily accessible at all time. However, based on the alleg deficient practice the following has been implemented: What corrective action(s) we be accomplished for those residents found to have be affected by the deficient practice: All delayed egress do of 8) have a sign posted that states "Push Until Alarm Sou Door Can Be Opened In 15 Seconds". The signs were posted on September 19 th 2011.	s s. s. ged ang vill en ors (8 t. unds.
	Maintenance As 09/02/11 at 12 hall exit door for provided with a magnetic lock loot provided w on an interview Environmental	vation with the Supervisor and the ssistant on 2:41 p.m., the 100 rom the facility was a delayed egress but the door was ith a sign. Based			How will you identify other residents having the poten to be affected by the same deficient practice and what corrective action will be tale. All residents have the potential to be affected by the alleged deficient practice. All delayed egress do of 8) have a sign posted that states "Push Until Alarm Soc Door Can Be Opened In 15 Seconds". The signs were posted on September 19 th 2011.	tial cen: e ors (8 t unds.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	155756	A. BUILDING	01	09/02/2011	
		100100	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/02/2011	
NAME OF F	PROVIDER OR SUPPLIER			V JEFFERSON BLVD		
	RY MEADOWS		FORT	WAYNE, IN46804		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
		y were supplied	1110		3.112	
				What measures will be put	into	
	with a delayed egress magnetic lock that would release in fifteen seconds when pressed. None of these exit doors were provided a			place or what systemic		
				changes will you make to		
				ensure that the deficient practice does not recur:		
	sign.	s were provided a		practice account recail.		
	3.1–19(b)			· All delayed egress do		
				of 8) have a sign posted that		
				states "Push Until Alarm Sou Door Can Be Opened In 15	inas.	
				Seconds". The signs were		
				posted on September 19 th 2011.		
				· The Maintenance Dire		
				will monitor all egress doors		
				ensure the signs are in place The Maintenance	; .	
			Director/Designee will in-service		vice	
				all managers to monitor egre		
				doors to ensure the signs an place. In-service will be	e in	
				completed by 10/2/11.		
				The Maintenance Dire	ector	
				is in charge of program		
				compliance		
				How the corrective action(s)	
				will be monitored to ensure	the	
				deficient practice will not re	·	
				i.e., what quality assurance program will be put into pla	I	
				Program will be but into bit		
				· A CQI monitoring tool		
				called Egress Door Signs wi	I	
				utilized every week x 4, mon 3 and quarterly x 2.	uny X	
				Data will be collected	by	
				Maintenance Director/Design	nee	
				and submitted to the CQI		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155756	A. BUILDI	ING	01	09/02/2	
		100100	B. WING	CTDEET AI	DDRESS, CITY, STATE, ZIP CODE	00/02/2	
NAME OF I	PROVIDER OR SUPPLIER				JEFFERSON BLVD		
COVENT	RY MEADOWS				/AYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
K0046 SS=E	Emergency lighting duration is provided 18.2.9.1 Based on obserinterview, the frequires of at least duration were to annually in accordanced on eleastery powered lighting system for a minimum annual test shadevery required emergency light less than 1 ½ frequipment shade operational for test. Written residence of the system	acility failed to mergency light ast 1½ hour ested monthly and ordance with LSC Periodic Testing of nting Equipment tional test shall be every required d emergency at 30 day intervals of 30 seconds. An Il be conducted on battery powered ting system for not nour duration. Il be fully the duration of the	K004	46	committee. If threshold is not met, an action plan will be developed. Non-compliance with facility procedures may result disciplinary action up to and including termination. Completion Date: 10/2/20 K 046 NFPA 101 Life Safety Code Standard It is the practice of this facility ensure all emergency lighting provided for at least a 1 ½ he duration. However, based on alleged deficient practice the following has been implement. What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice: All emergency lighting tested on September 20, 20°. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the	y to g is our in the inted: was 11. tial ten:	10/02/2011

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		155756	B. WIN	LDING IG		09/02/2011
	PROVIDER OR SUPPLIEI	!! ?		7843 W	JEFFERSON BLVD VAYNE, IN46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	authority havir deficient pract occupants in the visitors restroct rooms on the and 500 halls.	or inspection by the or inspection. This ing jurisdiction. This ice could affect any one main entrance or and the shower 100, 200, 300, 400			alleged deficient practice. All emergency lighting tested on September 20, 20. What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur	into
	Environmental Maintenance A 09/02/11 from p.m., battery of lights were obstrestroom near and the in the restroom and the 100, 200, Based on an in Maintenance S time of observ aware of the bolights and ther records of a mannual test regards.	oservations with the Supervisor and the ssistant on 12:35 p.m. to 2:15 operated emergency served in the visitors the main entrance 300 hall visitors the shower rooms of 400 and 500 halls. terview with the upervisor at the ations, he was not attery operated efore no written onthly test or an garding the battery gency lights were			All emergency lighting tested on September 20, 20. All emergency lighting put on a monthly and annual preventative maintenance schedule to be completed by Maintenance Director/Design. The Maintenance Director/Designe will in-serve Maintenance Assistant on the preventative maintenance schedule by October 2, 2011. The Maintenance Directories in charge of program compliance. How the corrective action(s will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plate. A CQI monitoring tool called Emergency Lighting wutilized every monthly x 3 an quarterly x 2. Data will be collected Maintenance Director/Designand submitted to the CQI	test test the nee. vice e . ctor the ecur, ites d by
					committee. If threshold is met, an action plan will be	not

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPLETED
		155756	B. WIN			09/02/2011
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L			JEFFERSON BLVD	
COVENT	RY MEADOWS				VAYNE, IN46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	TE COMPLETION DATE
IAU	REGULATORT OR	LSC IDENTIFTING INFORMATION)	+	IAU		DATE
					developed.Non-compliance with fac	ility
					procedures may result in	""ty
					disciplinary action up to and	
					including	
					termination.	
			1		Completion date: 10/2/2011	
K0056		atic sprinkler system,				
SS=F	installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with					
NFPA 25, Standard for the Inspection, Testing,						
		of Water-Based Fire				
	Protection System	ns. There is a reliable,				
		upply for the system. The				
		d with waterflow and tamper				
		e connected to the fire 18.3.5.				
	•		l vc	056	K 056 NFPA 101 Life Safety	10/02/2011
	Based on obser		Ku	1036	Code Standard	10/02/2011
	interview, the f	acility failed to			It is the practice of this facility	v to
	ensure comple	te coverage of the			have an automatic sprinkler	,
	sprinkler syste	m was provided for			system , installed in accorda	nce
	1 of 1 commun	nication rooms in			with NFPA 13 with approved	
	accordance wit				components, devices, and	,
		e Installation of			equipment, to provide compl	
					coverage of all portions of the	
		ms. The main fire			facility. However, based on talleged deficient practice the	
	alarm panel is				following has been implemen	
	communication				5 2 2 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	deficient practi	ce could affect all				
	occupants.				What corrective action(s) w	/ill
					be accomplished for those	
	Findings includ	le:			residents found to have been	en
					affected by the deficient	
					practice:	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155756	B. WING		09/02/2011
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
				V JEFFERSON BLVD	
COVENT	RY MEADOWS		FORT	WAYNE, IN46804	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		vation with the		· A new sprinkler system	m is
	Environmental	Supervisor and the		being added to the	11 15
	Maintenance Assistant on 09/02/11 at 12:55 p.m., the			communication room by Oct	ober
				2, 2011.	
	communication	room located			
	within the nour	rishment pantry was		How will you identify other	
	not provided w	ith a sprinkler		residents having the poten	
	I	head. Based on an interview with		to be affected by the same	•
	the Environmer	ntal Supervisor at		deficient practice and what	•
		the time of observation, he stated		corrective action will be tak	ken:
	a wall was constructed to make an				
	enclosure for c			 All residents have the potential to be affected by the 	
	room.	ommunication		alleged deficient practice.	
	100111.			A new sprinkler system	m is
	2 1 10/b)		com	being added to the	
	3.1-19(b)			communication room by Oct	ober
				2, 2011.	
				What measures will be put	into
				place or what systemic changes you will make to	
				ensure that the deficient	
				practice does not recur:	
				A many annihilation (
				 A new sprinkler system being added to the 	m is
				communication room by Oct	ober
				2, 2011.	
				The new sprinkler sys	
				will be monitored and tested	
				an ongoing quarterly basis to ensure it is in working condition	•
				The testing will be	
				documented in the preventa	tive
				maintenance manual by the	
				Maintenance Director/Desig	•
				The Maintenance Dire	ector

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155756	B. WING		09/02/2011
	ROVIDER OR SUPPLIER		7843 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON BLVD // VAYNE, IN46804	•
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	T	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
				is in charge of program compliance	
				How the corrective action(will be monitored to ensur deficient practice will not i i.e., what quality assuranc program will be put into pl	e the recur, e ace:
				will be monitored and tested an ongoing quarterly basis is ensure it is in working cond. The testing will be documented in the preventa maintenance manual by the Maintenance Director/Desig. A CQI monitoring too called Sprinkler System will	ative ginee.
				utilized every quarter x 2. Data will be collected Maintenance Director/Design and submitted to the CQI committee. If threshold is met, an action plan will be developed. Non-compliance with facility procedures may resu	not ult in
K0067 SS=F		ecifications. 9.2, 18.5.2.1,		Completion date: 10/2/201	1
	Based on obserinterview, the f	vation and	K0067	K 067 NFPA 101 Life Safety Code Standard It is the practice of this facili	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLE	
		155756	B. WIN	NG		09/02/20	11
NAME OF	PROVIDER OR SUPPLIEI	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON BLVD		
COVEN	TRY MEADOWS			FORT V	VAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of dampers we	re inspected and			ensure heating, ventilating, a air conditioning comply with		
	provided neces	ssary maintenance			provisions of section 9.2 and		
	at least every f	our years in			installed in accordance with	I .	
	accordance wit	th NFPA 90A. LSC			manufacturer's specifications		
	9.2.1 requires	air conditioning,			However, based on the alleg		
	I	ating ductwork and			deficient practice the following	ng	
	related equipm	-			has been implemented:		
	accordance wit				What corrective action(s) w	/ill	
		ne Installation of			be accomplished for those	I .	
		ng and Ventilating			residents found to have be	en	
	Systems. NFPA 90A, 1999 Edition,				affected by the deficient		
	3.4.7, Maintenance, requires at least every 4 years, fusible links				practice:		
					· All dampers were		
	1 ' '				inspected and provided		
		ed; all dampers			necessary maintenance by t	he	
	1	d to verify they fully			Maintenance Director and		
		n, if provided, shall			Maintenance Assistant by		
	be checked, ar	nd moving parts			October 2, 2011.		
	shall be lubrica	ated as necessary.			How will you identify other		
	This deficient	practice affects all			residents having the poten		
	occupants.				to be affected by the same		
					deficient practice and what		
	Findings includ	de:			corrective action will be tak	(en	
					· All dampers were		
	Based on obse	rvation with the			inspected and provided		
		Supervisor and the			necessary maintenance by t	he	
	Maintenance A	•			Maintenance Director and		
		2:51 p.m., a damper			Maintenance Assistant by		
		•			October 2, 2011. All residents have the		
	was observed in the ventilation system in the 200 hall mechanical				potential to be effected by th		
	1	on interview with			alleged deficient practice.		
		ce Director at the			What measures will be put	into	
		ation, there were			place or what systemic changes you will make to		
	dampers locate	ed throughout the					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DINC	01	COMPLETED	
		155756	A. BUIL B. WING			09/02/20	011
			B. WING		ADDRESS CITY STATE ZIR CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
OOV/ENT					/ JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	WAYNE, IN46804		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility in the v	entilation system			ensure that the deficient		
	but the exact r	number was			practice does not recur		
		stated the dampers					
					· All dampers were		
		inspected since the			inspected and provided	ha	
	building was co	onstructed in 2006.			necessary maintenance by to Maintenance Director and	ile	
					Maintenance Assistant by		
	3.1-19(b)				October 2, 2011.		
		、 ,			· All dampers will be ad	ded	
					to the preventative maintena		
					schedule and will be inspect	ed	
					and provided necessary		
					maintenance at least every f	our	
					years. The Maintenance Dire	actor	
					is in charge of program	,ClOi	
					compliance.		
					How the corrective action(s	·	
					will be monitored to ensure		
					deficient practice will not re		
					i.e., what quality assurance		
					program will be put into pla	ice:	
					· A CQI monitoring tool		
					called Damper Inspection wi		
					utilized quarterly x 2.	20	
					Data will be collected	by	
					Maintenance Director/Design	nee	
					and submitted to the CQI		
					committee. If threshold is no	ot	
			1		met, an action plan will be		
					developed.	sility	
					 Non-compliance with facting procedures may result in 	лицу	
					disciplinary action up to and		
					including		
					termination.		
			1				
			1				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155756		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 09/02/2	ETED	
	PROVIDER OR SUPPLIER		<u>'</u>	7843 W	ADDRESS, CITY, STATE, ZIP CODE JUSTERSON BLVD VAYNE, IN46804		
(X4) ID PREFIX TAG K0104 SS=F	SUMMARY S (EACH DEFICIENCE REGULATORY OR Penetrations of sm protected in accord Based on observations of the provided with a LSC 101 section approved dampresist the passabe provided for opening or duction opening or duction occupants. Findings include Based on observations in the that penetrated wall in the that penetrated wall in the 100 Based on an intenvironmental time of observations in the that penetrated wall the that penetrated wall in the 100 Based on an intenvironmental time of observations in the that penetrated wall in the 100 Based on an intenvironmental time of observations in the 100 Based on an intenvironmental time of	vation and acility fail to ensure penetrations were a smoke damper. In 8.3.5.1 states an our designed to age of smoke shall reach air transfer t penetration of a barrier. This are could affects all e: vations with the Supervisor on 2:35 p.m. to 2:45 ampers were not ventilation duct at the smoke barrier and 300 and 400 halls. Serview with the Supervisor at the ations, the apenetrations of	K	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Completion date: 10/2/2011 K 104 NFPA 101 Life Safety Code Standard It is the practice of this facility ensure penetrations of smok barriers by ducts are protecte accordance with 8.3.6. Howe based on the alleged deficien practice the following has be implemented: What corrective action(s) where the same deficient practice in the same barriers (100, 200, 300, 400, 500 Halls) with ducts will be protected by the same deficient practice and what corrective action will be taken action of the same deficient practice and what corrective action will be taken action will be taken action will be protected by installation of dampers. All penetrations of smoke affected by the same deficient practice and what corrective action will be taken action will be taken action will be taken action will be taken action by installation of dampers.	y to e ed in ever ht en bke and	(X5) COMPLETION DATE 10/02/2011
the smoke barrier wall on the 200 and 500 halls would be the same way.					All residents have the potential to be effected by the alleged deficient practice. What measures will be put		

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPLETED 09/02/2011		
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN46804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE			
	3.1-19(b)			place or what systemic changes you will make to ensure that the deficient practice does not recur:			
				All penetrations of sm barriers (100, 200, 300, 400 500 Halls) with ducts will be protected by installation of dampers. All new dampers will added to the preventative maintenance schedule and inspected and provided necessary maintenance at levery four years. Maintenance Director responsible for program compliance. How the corrective action(will be monitored to ensure deficient practice will not a substantial with a sure of the sur	be will be east is s) e the recur,		
K0130 SS=E	OTHER LSC DEF	ICIENCY NOT ON 2786		i.e., what quality assurance program will be put into please. A CQI monitoring too called Damper Inspection we utilized quarterly x 2. Data will be collected Maintenance Director and submitted to the CQI comm of threshold is not met, an aplan will be developed. Non-compliance with facility procedures may resurd disciplinary action up to and including termination. Completion date: 10/2/201	ace: I vill be by ittee. ction		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		01	COMPLETED	
		155756	A. BUILI B. WING			09/02/2	011
		<u> </u>	B. ((11)		ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF PROVIDER OR SUPPLIER					/ JEFFERSON BLVD		
COVENTRY MEADOWS			FORT WAYNE, IN46804				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)				DEFICIENCY)		DATE
	Based on observation, record		K(K0130 K 130 NFPA 101 Miscella			10/02/2011
	review and inte	review and interview; the facility			It is the practice of this facility to comply with other LSC Deficiency not on 2786. However, based on		
	failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition,						
					the alleged deficient practice		
					following was implemented:		
	the Standard for Fire Doors and			What corrective action(s) w		ill	
	Fire Windows, Section 15-2.4.3						
	requires all horizontal or vertical				residents found to have be	en	
	sliding and rolling fire doors to be				affected by the deficient practice:		
	_	inspected and tested annually to					
	· ·	er operation and			The rolling door at the		
	1	•		kitchen window in the main dining			
	full closure. Resetting of the release mechanism shall be done			room will be inspected by October 2, 2011 to ensure care and		•	
	in accordance with the manufacturer's instructions. A				maintenance are in accordance		
					with NFPA 80.		
		written record shall be maintained			How will you identify other residents having the potential to be affected by the same deficient practice and what		
	and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room.						
					corrective action will be tak	en:	
					. The relling door of the		
					 The rolling door at the kitchen window in the main of 		
	Findings includ	de:			room will be inspected by Oc		
					2, 2011 to ensure care and		
	Based on obse	rvation with the			maintenance are in accordar	nce	
	Environmental Supervisor and the Maintenance Assistant on 09/02/11 at 2:00 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. The rolling fire				with NFPA 80.		
					All residents in the ma		
					dining room have the potential to be affected by the alleged deficient practice.		
					What measures will be put into place or what systemic		
	door was not i	n a corridor wall.			changes you will make to		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/02/2011		
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN46804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Based on interview with the Environmental Supervisor at the time of observation, there has never been an annual inspection or test of the rolling fire door to check for proper operation and		ID PREFIX TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ensure that the deficient practice does not recur: The rolling door at the kitchen window in the main dining room will be added to the preventative maintenance schedule and will be inspected		(X5) COMPLETION DATE
	check for proper operation and full closure. 3.1–19(b)				and provided necessary maintenance on an annual b Maintenance Director responsible to oversee compliance. How the corrective action(s will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla A CQI monitoring tool called Rolling Fire Door will b utilized quarterly x 2. Data will be collected Maintenance Director/Design and submitted to the CQI Committee. If threshold is no met, an action plan will be developed. Non-compliance with facility procedure may result disciplinary action up to and including termination. Compliance date: 10/2/201	is s) e the ecur, e ace: be by nee ot	